FLEXCOMP REIMBURSEMENT VOUCHER

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 16868 (Rev. 03-05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS ● PO Box 1657 ● Bismarck ● North Dakota 58502-1657

(701) 328- 3900 ● 1-800-803-7377 ● Fax 701-328-3920

RESET

Please follow the claim filing instructions on the back of the claim form to avoid delays in claims processing.

SECTION A PARTICIPANT INFORMATION

Plan Participant's Name (Last, First, Mi)			Employee ID Number **(Required)**
Department Name	Department Number	Work Phone Number	Social Security Number **(Required)**

SECTION B MEDICAL EXPENSES

Service Date	Provider Name	Amount	Service Date	Provider Name	Amount

Total Medical Reimbursement Request: $ 0.00

SECTION C NDPERS USE ONLY

Service From	Service To	Submitted Amount	Denied Amount	Claim ID

SECTION D DEPENDENT CARE EXPENSES

Provider Name	Tax ID or SSN	Provider's Signature	Expense Dates		Amount
			From	Through	

Total Dependent Care Reimbursement Request: $ 0.00

SECTION E NDPERS USE ONLY

Service From	Service To	Submitted Amount	Denied Amount	Claim ID

SECTION F CERTIFICATION – READ CAREFULLY

The undersigned participant in the Plan certifies the following:

- All expenses for which reimbursement is claimed by submission of this form were incurred during a period while the undersigned was a participant in the Plan.
- The expenses were for services received by the participant or his/her dependent(s) as defined in the Plan.
- The expenses have not been reimbursed and are not reimbursable under any other health plan coverage.
- Any dependents for which the participant selected dependent care benefits reside in a parent/child relationship and/or are legally dependent on the participant for their support. The child must reside with the employee for more than half of the taxable year.
- The undersigned fully understands that he or she alone is fully responsible for the accuracy of all information relating to this claim and that unless an expense for reimbursement is a proper expense under the Plan, the undersigned may be liable for payment of all related taxes including federal, state, and FICA tax on amounts paid from the Plan which relate to such expense.
- The undersigned agrees that the reimbursement associated with their dependent care reimbursement request is for dependent care expenses that have been incurred.

Plan Participant's Signature _____ Date of Signature _____

ORIGINAL TO NDPERS – PLEASE RETAIN A COPY FOR YOUR RECORDS

In order for PERS to comply with the IRS requirement for claims substantiation, the following outlines the acceptable forms of documentation to submit in order to ensure your claim will be processed without delay:

1. A copy of the page of the Explanation of Benefits (EOB) that lists the breakdown of charges and benefits indicating the deductible, co-insurance, co-payment, etc. from your health, dental, or vision insurance carrier. No other documentation is necessary if you submit the EOB. For prescription drugs, the documentation (prescription receipt or provider statement) must show the Rx number along with the name of the drug being dispensed. The EOB is also acceptable for reimbursement of prescription drug expenses.

2. If you do not have insurance coverage, a statement from the provider is required. The statement must include the provider's name, patient name, a fully itemized list of services received, and the date of services. Statements with only a balance forward or balance due cannot be accepted.

3. Orthodontic expenses may be reimbursed on a monthly payment schedule as payment is required and paid. You must submit a paid receipt from your orthodontist or a photocopy of the monthly coupon and your check. To be reimbursed for orthodontic expenses that will be incurred during the plan year, a copy of the contract or a statement from the provider must be submitted along with a receipt showing date and amount of payment.

4. Detailed cash register receipts will be acceptable documentation for over-the-counter drugs and contact lense solutions.

5. For Dependent Care claims your provider must complete Section D or provide a receipt with the following information:
    - Name of Provider
    - Tax Identification Number or Social Security Number
    - Actual dates on which care was provided (not billing payment date)
    - Amount of dependent care expense

    Eligible Dependent Care Expenses
    - Must be for the purpose of enabling you or you and your spouse to be employed.
    - Be for a child under 13 years of age who is your dependent under Federal tax laws. The child must live with the employee for more than one-half the taxable year.
    - Be provided by someone other than your spouse or another dependent child. (If your day care provider is a relative, list relationship.)
    - The dependent care account can also be used for the care of a spouse or dependent over the age of 13 who is incapable of self-care. The adult dependent who is incapable of self care must live with the employee for more than one-half the taxable year and not have more then $3,200 per year in gross income.

    Ineligible Expenses

    You cannot obtain reimbursement for:
    - Food, transportation, registration, or supply fees if they are billed separately from the dependent care expenses.
    - Kindergarten expenses that are primarily educational in nature, regardless of half or full day, private or public school, state mandated or voluntary. However, if your day care provides kindergarten that is run on the order of a nursery school, with the child's education merely incidental to the care provided and the cost cannot be separated from the cost of the child care, the entire amount can be considered an eligible expense.

Services that require pre-payment cannot be reimbursed until after the services have been rendered.

Requests filed without the above documentation <u>cannot</u> be processed and will be returned.

Send or deliver the completed voucher and all supporting documentation to:

NDPERS
400 East Broadway Avenue – Suite 505
PO Box 1657
Bismarck ND 58502-1657